FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029975

Facility Name: WILSON CARE, INC.

Address: 4544 N. HAZEL STREET (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 561-7241 **Fax #** (773) 728-2606

IDPA ID Number: 36-3379568

Date of Initial License for Current Owners: 09/01/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) CARY BUXBAUM C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	198	Intermediate (ICF)	198	72,468	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	198	TOTALS	198	72,468	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	65,927	1,317		67,244	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	65,927	1,317		67,244	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.79%

D. How many bed-hold days during this year were paid by Public Aid? 2,024 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/31/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified N/A and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	140,474	28,056	32,924	201,454		201,454	(20,268)	181,186			1
2	Food Purchase		233,419		233,419	(17,623)	215,796	(46)	215,751			2
3	Housekeeping	97,528	27,174		124,702		124,702	637	125,339			3
4	Laundry		21,095	7,073	28,168		28,168		28,168			4
5	Heat and Other Utilities			118,811	118,811		118,811	2,273	121,084			5
6	Maintenance	34,817	28,369	293,516	356,702		356,702	(191,793)	164,909			6
7	Other (specify):*							7,747	7,747			7
8	**TOTAL General Services**	272,819	338,113	452,324	1,063,256	(17,623)	1,045,633	(201,450)	844,184			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,009,389	8,948	54,605	1,072,942		1,072,942	(20,374)	1,052,568			10
10a	Therapy			17,580	17,580		17,580	(5,652)	11,928			10a
11	Activities	108,708	6,593		115,301		115,301		115,301			11
12	Social Services	67,945	4,908		72,853		72,853		72,853			12
13	Nurse Aide Training			295	295		295		295			13
14	Program Transportation			1,500	1,500		1,500		1,500			14
15	Other (specify):*							5,203	5,203			15
16	**TOTAL Health Care and Programs**	1,186,042	20,449	77,580	1,284,071		1,284,071	(20,823)	1,263,248			16
	C. General Administration											
17	Administrative	87,765		307,217	394,982		394,982	(92,995)	301,987			17
18	Directors Fees											18
19	Professional Services			158,606	158,606	(2,500)	156,106	(91,764)	64,342			19
20	Dues, Fees, Subscriptions & Promotions			20,852	20,852		20,852	(4,098)	16,754			20
21	Clerical & General Office Expenses	74,757	19,027	80,602	174,386		174,386	7,359	181,745			21
22	Employee Benefits & Payroll Taxes			230,179	230,179	17,623	247,802		247,802			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,667	2,667		2,667	745	3,412			24
25	Other Admin. Staff Transportation			2,003	2,003		2,003	3,072	5,075			25
26	Insurance-Prop.Liab.Malpractice			59,483	59,483		59,483	1,118	60,601			26
27	Other (specify):*							25,035	25,035			27
28	**TOTAL General Administration**	162,522	19,027	861,609	1,043,158	15,123	1,058,281	(151,528)	906,753			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,621,383	377,589	1,391,513	3,390,485	(2,500)	3,387,985	(373,801)	3,014,184			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

WILSON CARE, INC.
0029975
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	17,623	
2	FOOD		17,623

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	2,500	
19	PROFESSIONAL FEES		2,500

To reclass cost of appealing real estate taxes

Facility Name & ID Number WILSON CARE, INC. #0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			83,510	83,510		83,510	81,367	164,877			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,558	1,558		1,558	421,947	423,505			32
33	Real Estate Taxes			76,533	76,533	2,500	79,033	4,628	83,661			33
34	Rent-Facility & Grounds			614,280	614,280		614,280	(614,280)				34
35	Rent-Equipment & Vehicles			13,794	13,794		13,794	10,381	24,175			35
36	Other (specify):*							10,991	10,991			36
37	**TOTAL Ownership**			789,675	789,675	2,500	792,175	(84,966)	707,209			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			108,702	108,702		108,702		108,702			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			108,702	108,702		108,702		108,702			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,621,383	377,589	2,289,890	4,288,862		4,288,862	(458,767)	3,830,095			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,751)	30		9
10	Interest and Other Investment Income	(77,748)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(46)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,838)	21		24
25	Fund Raising, Advertising and Promotional	(2,283)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(23,654)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(174,369)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (310,689)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(148,078)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (148,078)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (458,767)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WILSON CARE, INC.

ID# 0029975

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ 2,363	6	1
2	Nonallowable Travel Expense	(200)	25	2
3	Cable TV	(1,277)	20	3
4	Ill Council-COPE Dues	(297)	20	4
5	Collections	(89)	19	5
6	Interest on Insurance Financing	(1,558)	32	6
7	Jury Duty Income	(52)	10	7
8	Rent of space for pay phones	(377)	35	8
9	Capitalized Repairs & Maintenance	(171,096)	6	9
10	Seminar Expense	(30)	24	10
11	City Sales Tax	(1,756)	20	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(174,369)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(20,268)							(20,268)	1
2	Food Purchase	(46)											(46)	2
3	Housekeeping			637									637	3
4	Laundry													4
5	Heat and Other Utilities			860	1,413								2,273	5
6	Maintenance	(168,733)		530	(11,163)	(12,427)							(191,793)	6
7	Other (specify):*				758	6,989							7,747	7
8	**TOTAL General Services**	(168,779)		2,027	(8,992)	(25,706)							(201,450)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(52)			(20,322)								(20,374)	10
10a	Therapy					(5,652)							(5,652)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				3,196	2,007							5,203	15
16	**TOTAL Health Care and Programs**	(52)			(17,126)	(3,645)							(20,823)	16
	C. General Administration													
17	Administrative			14,872	(61,962)	(33,025)		(12,880)					(92,995)	17
18	Directors Fees													18
19	Professional Services	(89)		(89,922)	(13,727)	11,884		90					(91,764)	19
20	Fees, Subscriptions & Promotions	(5,613)		383	1,073			59					(4,098)	20
21	Clerical & General Office Expenses	(47,492)		49,383	5,338			130					7,359	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(30)		194	581								745	24
25	Other Admin. Staff Transportation	(200)		676	2,596								3,072	25
26	Insurance-Prop.Liab.Malpractice			434	572			112					1,118	26
27	Other (specify):*			7,758	4,788	11,982		507					25,035	27
28	**TOTAL General Administration**	(53,424)		(16,222)	(60,741)	(9,159)		(11,982)					(151,528)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(222,255)		(14,195)	(86,859)	(38,510)		(11,982)					(373,801)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILSON CARE, INC. # 0029975 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(8,751)	81,609	3,170	5,339								81,367	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(79,306)	496,770	1,237	3,162			84					421,947	32
33	Real Estate Taxes			1,600	3,028								4,628	33
34	Rent-Facility & Grounds		(614,280)										(614,280)	34
35	Rent-Equipment & Vehicles	(377)		2,735	6,464			1,559					10,381	35
36	Other (specify):*		10,991										10,991	36
37	**TOTAL Ownership**	(88,434)	(24,910)	8,742	17,993			1,643					(84,966)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(310,689)	(24,910)	(5,453)	(68,866)	(38,510)		(10,339)					(458,767)	45

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule Attached		See Schedule Attached		See Schedule Attached		
				Wilson Care LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 614,280	Wilson Care LLC	100.00%	$	$ (614,280)	1
2	V	32	Interest Income	216	Wilson Care LLC	100.00%		(216)	2
3	V	32	Interest Expense		Wilson Care LLC	100.00%	496,986	496,986	3
4	V	30	Depreciation		Wilson Care LLC	100.00%	81,609	81,609	4
5	V	36	Amortization		Wilson Care LLC	100.00%	10,991	10,991	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 614,496			$ 589,586	$ * (24,910)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 637	$ 637	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	860	860	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	530	530	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	14,872	14,872	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,978	1,978	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	383	383	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	49,383	49,383	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	194	194	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	676	676	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	434	434	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	7,758	7,758	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	3,170	3,170	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,237	1,237	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,600	1,600	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	2,735	2,735	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	91,900	PREFERRED BOOKKEEPING	100.00%		(91,900)	32
33	V	19	COMPUTER	4,752	PREFERRED BOOKKEEPING	100.00%	4,752		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 96,652			$ 91,199	$ * (5,453)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 1,413	$ 1,413	15
16	V	6	REPAIRS AND MAINT.	17,820	S.I.R. MANAGEMENT, INC.	100.00%	6,657	(11,163)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	758	758	17
18	V	10	NURSING	39,204	S.I.R. MANAGEMENT, INC.	100.00%	18,882	(20,322)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	3,196	3,196	19
20	V	17	ADMINISTRATIVE	69,492	S.I.R. MANAGEMENT, INC.	100.00%	7,530	(61,962)	20
21	V	19	PROFESSIONAL FEES	16,044	S.I.R. MANAGEMENT, INC.	100.00%	2,317	(13,727)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	1,073	1,073	22
23	V	21	CLERICAL & GENERAL	20,196	S.I.R. MANAGEMENT, INC.	100.00%	25,534	5,338	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	581	581	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,596	2,596	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	572	572	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	4,788	4,788	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	5,339	5,339	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	3,162	3,162	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	3,028	3,028	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	6,464	6,464	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 162,756			$ 93,890	$ * (68,866)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 20,196	S.I.R. MANAGEMENT, INC.	100.00%	$ 5,452	$ (14,744)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	917	917	16
17	V	17	ADMIN./LEGAL SALARIES	120,000	S.I.R. MANAGEMENT, INC.	100.00%	86,975	(33,025)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	11,884	11,884	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	11,982	11,982	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB	17,580	S.I.R. MANAGEMENT, INC.	100.00%	11,928	(5,652)	22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	2,007	2,007	23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	40,876	S.I.R. MANAGEMENT, INC.	100.00%	28,449	(12,427)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	4,953	4,953	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	12,000	S.I.R. MANAGEMENT, INC.	100.00%	6,476	(5,524)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,119	1,119	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 210,652			$ 172,142	$ * (38,510)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 38,031	$ 38,031	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	38,031	CCS EMPLOYEE BENEFIT GROUP	100.00%		(38,031)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 38,031			$ 38,031	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 90	$ 90	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	59	59	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	130	130	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	112	112	18
19	V	32	INTEREST		ECM OWNERS COUNCIL	100.00%	84	84	19
20	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	1,559	1,559	20
21	V	17	MANAGEMENT FEES	21,600	ECM OWNERS COUNCIL	100.00%		(21,600)	21
22	V								22
23	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	8,720	8,720	23
24	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	507	507	24
25	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%	0		25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 21,600			$ 11,261	$ * (10,339)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Stockholder	Administrative	11.11%	See Attached	4.71	9.42	Alloc Salary	$ 27,489	17-7	1
2	NoahWolf	Stockholder	Administrative	5.56%	See Attached	3	7.50	Mgmt Fees	48,000	17-3	2
3	Nenita Guzman	Relative	Dietary	0.00	See Attached	5.75	10.45	Alloc Salary	5,452	1-7	3
4	Arturo Rominiquit	Relative	Clerical	0.00	See Attached	4.18	10.45	Alloc Salary	2,287	21-7	4
5	Eric Rothner	Stockholder	Administrative	20.00%	See Attached	0.66	0.92	Alloc Salary	7,000	17-7	5
6	Howard Geller	Stockholder	Administrative	4.44%	See Attached	2	3.08	Mgmt Fees	48,000	17-3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 138,228		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	878,492	11	$ 6,088	$	91,900	$ 637	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	878,492	11	8,220		91,900	860	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	878,492	11	5,069		91,900	530	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	878,492	11	142,165	142,165	91,900	14,872	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	878,492	11	18,910		91,900	1,978	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	878,492	11	3,657		91,900	383	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	878,492	11	472,061	403,426	91,900	49,383	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	878,492	11	1,858		91,900	194	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	878,492	11	6,465		91,900	676	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	878,492	11	4,146		91,900	434	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	878,492	11	74,163		91,900	7,758	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	878,492	11	30,298		91,900	3,170	12
13	32	INTEREST	BOOK./ACCNT.INCOME	878,492	11	11,823		91,900	1,237	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	878,492	11	15,297		91,900	1,600	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	878,492	11	26,147		91,900	2,735	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						4,752	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 826,367	$ 545,591		$ 91,199	25

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	642,911	10	$ 13,508	$	67,244	$ 1,413	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	642,911	10	63,644	42,834	67,244	6,657	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	642,911	10	7,250		67,244	758	3
4	10	NURSING	PATIENT DAYS	642,911	10	180,529	180,529	67,244	18,882	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	642,911	10	30,553		67,244	3,196	5
6	17	ADMINISTRATIVE	PATIENT DAYS	642,911	10	71,994	71,994	67,244	7,530	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	642,911	10	22,153		67,244	2,317	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	642,911	10	10,256		67,244	1,073	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	642,911	10	244,124	177,193	67,244	25,534	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	642,911	10	5,556		67,244	581	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	642,911	10	24,821		67,244	2,596	11
12	26	INSURANCE	PATIENT DAYS	642,911	10	5,468		67,244	572	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	642,911	10	45,778		67,244	4,788	13
14	30	DEPRECIATION	PATIENT DAYS	642,911	10	51,045		67,244	5,339	14
15	32	INTEREST	PATIENT DAYS	642,911	10	30,234		67,244	3,162	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	642,911	10	28,948		67,244	3,028	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	642,911	10	61,803		67,244	6,464	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 897,664	$ 472,550		$ 93,890	25

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	642,911	10	$ 52,122	$ 52,122	67,244	$ 5,452	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	642,911	10	8,770		67,244	917	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	642,911	10	831,558	831,558	67,244	86,975	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	642,911	10	113,620		67,244	11,884	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	642,911	10	$ 114,558	$	67,244	$ 11,982	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	56,277	56,277	17,580	11,928	8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 9,470	$	17,580	$ 2,007	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	237,604	10	165,366	165,366	40,876	28,449	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	237,604	10	$ 28,790	$	40,876	$ 4,953	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	67,672	67,672	12,000	6,476	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	11,698		12,000	1,119	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,459,901	$ 1,172,995		$ 172,142	25

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 38,031	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 38,031	25

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 676-2026
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 400	$	21,600	$ 90	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		21,600	59	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	579		21,600	130	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	496		21,600	112	4
5	32	INTEREST	ECMOC MGMNT FEE INC.	96,000	9	374		21,600	84	5
6	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,931		21,600	1,559	6
7										7
8										8
9	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	81,858	81,858	4	8,720	9
10	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,762		4	507	10
11	17	ADMIN. SALARY	DIRECT ALLOCATION							11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 95,664	$ 81,858		$ 11,261	25

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Nomura		X	Mortgage	$48,561.00	3/01/95	$ 5,817,265	$ 5,578,606	02/21/08	8.6900	$ 496,986	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$48,561.00		$ 5,817,265	$ 5,578,606			$ 496,986	9
	B. Non-Facility Related*											
10	Supplemental Schedule										(73,481)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (73,481)	14
15	TOTALS (line 9+line14)						$ 5,817,265	$ 5,578,606			$ 423,505	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2	Interest Income										(77,748)	2
3	Interest Income -Bldg	X									(216)	3
4	Allocation-Preferred Bookkpng	X									1,237	4
5	Allocation-SIR Management	X									3,162	5
6	Allocation-ECM Owner's Coun	X									84	6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (73,481)	21

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	80,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	81,661	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,661	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	79,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	2,500	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	83,661	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	85,441	8
	1996	91,962	9
	1997	76,201	10
	1998	77,554	11
	1999	77,033	12

ACCRUAL=1999 BILL * 1.03 ROUNDED TO 79,500

ALLOCATION PREFERRED BOOKKEEPING $1,600

ALLOCATION SIR MANAGEMENT $3,028

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,020 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1985	$ 13,300	1
2					2
3	TOTALS			$ 13,300	3

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	198		1985		$ 1,539,800	$ 81,609	35	$ 43,994	$ (37,615)	$ 624,202	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1985	65,366	2,746	20	3,441	695	52,169	9
10	VARIOUS			1986	161,365	6,777	20	8,493	1,716	123,638	10
11	VARIOUS			1987	49,380	1,429	20	2,598	1,169	35,587	11
12	VARIOUS			1989	49,210	1,562	20	2,461	899	28,445	12
13	VARIOUS			1990	105,470	3,347	20	5,274	1,927	53,188	13
14	VARIOUS			1991	29,903	948	20	1,494	546	14,293	14
15	VARIOUS			1992	69,669	2,211	20	3,484	1,273	29,809	15
16	VARIOUS			1993	61,688	1,274	20	3,087	1,813	23,107	16
17	VARIOUS			1994	55,691	1,205	20	2,917	1,712	18,764	17
18	VARIOUS			1995	87,144	3,187	20	4,357	1,170	24,846	18
19	ELECTRICAL WORK			1996	54,911	1,408	20	2,746	1,338	13,501	19
20	WINDOW TREATMENTS			1996	10,230	1,179	20	512	(667)	2,517	20
21	WINDOWS			1996	4,254	490	20	213	(277)	1,029	21
22	COMPRESSOR			1996	2,267	261	20	113	(148)	518	22
23	REFINISH BATHTUBS			1996	9,230	237	20	462	225	1,964	23
24											24
25	PAGE 12-1 REP TOTALS				85,905	3,549		3,349	(200)	18,791	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				21,616	2,586		504	(2,082)	504	33
34	PAGE 12B TOTALS				335,616	11,775		6,139	(5,636)	6,521	34
35	PAGE 12A TOTALS				449,974	11,101		22,500	11,399	82,156	35
36	TOTAL (lines 4 thru 35)				$ 3,248,689	$ 138,881		$ 118,138	$ (20,743)	$ 1,155,549	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REFINISH BATHTUBS			1996	9,207	236	20	460	224	1,917	9
10	REFINISH BATHTUBS			1996	18,537	475	20	927	452	3,862	10
11	NEW BOILER			1996	37,116	952	20	1,856	904	7,888	11
12	REFINISH BATHTUBS			1996	32,972	845	20	1,649	804	6,733	12
13	UNDERGROUND TANK			1996	9,614		20	481	481	1,964	13
14	G&D SEWER			1996	5,800		20	290	290	1,329	14
15	ENVIRONMENTAL			1996	91,943		20	4,597	4,597	21,070	15
16	PAINTING & DECORATING			1996	17,312		20	866	866	3,031	16
17	FIRE ALARM UPGRADE			1997	58,437	1,498	20	2,922	1,424	10,714	17
18	VANITY TOPS			1997	8,041	206	20	402	196	1,474	18
19	FIRE ALARM UPGRADE			1997	29,045	858	20	1,452	594	5,635	19
20	FIRE DOOR			1997	3,238	83	20	162	79	594	20
21	ELEVATOR			1997	46,650	1,196	20	2,333	1,137	7,582	21
22	ELEVATOR WORK			1998	6,635	170	20	332	162	941	22
23	SECURITY SYSTEM			1998	5,956	1,144	20	298	(846)	820	23
24	NURSES STATION			1998	11,997	2,303	20	600	(1,703)	1,450	24
25	CARPET & MINI BLINDS			1998	875		20	44	44	114	25
26	WALLPAPER			1998	807		20	40	40	100	26
27	ELEVATOR PANELS			1998	2,145		20	107	107	268	27
28	ELEVATOR TEES			1998	2,427		20	121	121	292	28
29	VCT/NURSES STATION			1998	2,684		20	134	134	313	29
30	VCT/RECEPTION			1998	1,433		20	72	72	156	30
31	TUCKPOINTING			1999	5,300	136	20	265	129	508	31
32	HVAC WORK			1999	27,900	715	20	1,395	680	2,441	32
33	SIR REMODELING			1999	11,079	284	20	554	270	693	33
34	ROOFING			1999	975		20	49	49	98	34
35	BLINDS			1999	1,849		20	92	92	169	35
36	TOTAL (lines 4 thru 35)				$ 449,974	$ 11,101		$ 22,500	$ 11,399	$ 82,156	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELECRICAL			1999	2,719		20	136	136	263	9
10	CUBICLE CURTAINS			1999	2,453		20	123	123	205	10
11											11
12	HEAT COOL SLEVE			1999	1,650		20	83	83	90	12
13	PIPE REPLACEMENT			1999	3,618		20	181	181	241	13
14	2 NEW CAR GATES			1999	5,780		20	289	289	385	14
15	FLOORING			1999	1,234		20	62	62	72	15
16	PAINTING			2000	15,000		20	438	438	438	16
17	FLOOR & WALL TILE			2000	13,197	127	20	275	148	275	17
18	KITCHEN TILES			2000	13,147	98	20	219	121	219	18
19	PUMP (INCLUDES $3,407 FROM 6/30/00 CAP. PROJ.)			2000	5,677	30	20	71	41	71	19
20	TILE WORK			2000	62,060	331	20	776	445	776	20
21	DINING ROOM			2000	24,287		20	304	304	304	21
22	TILE WORK			2000	2,013	7	20	17	10	17	22
23	PAINTING			2000	15,000		20	375	375	375	23
24	PAINTING			2000	30,000		20	625	625	625	24
25	PAINTING			2000	30,000		20	375	375	375	25
26	FIRE DOORS			2000	35,264	7,053	20	1,175	(5,878)	1,175	26
27	ROOM DIVIDER			2000	20,600	4,120	20	172	(3,948)	172	27
28	WINDOW TREATMENT			2000	1,046		20	43	43	43	28
29	WINDOW TREATMENT			2000	1,044		20	26	26	26	29
30	KITCHEN REMODEL			2000	6,623		20	109	109	109	30
31	ELECTRIC WORK			2000	2,585		20	65	65	65	31
32	STOWELL REMODEL			2000	1,798		20	38	38	38	32
33	PAINTING			2000	5,900		20	25	25	25	33
34	PAINTING			2000	24,447		20	102	102	102	34
35	TILE WORK			2000	8,474	9	20	35	26	35	35
36	TOTAL (lines 4 thru 35)				$ 335,616	$ 11,775		$ 6,139	$ (5,636)	$ 6,521	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WATER HEATER			2000	5,120	1,024	20	171	(853)	171	9
10	LIGHTS FIXTURE			2000	7,807	1,562	20	98	(1,464)	98	10
11	RADIATOR			2000	1,055		20	53	53	53	11
12	MIXING VALVE			2000	1,138		20	57	57	57	12
13	CONCRETE			2000	1,500		20	56	56	56	13
14	BORDERS			2000	542		20	5	5	5	14
15	CARPET			2000	633		20	3	3	3	15
16	INTERIOR SUPPLY			2000	1,582		20	33	33	33	16
17	DINING A/C			2000	1,239		20	15	15	15	17
18	CONCRETE			2000	1,000		20	13	13	13	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 21,616	$ 2,586		$ 504	$ (2,082)	$ 504	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993	Alloc-SIR	$ 14,772	$ 469	35	$ 422	$ (47)	$ 3,165	4
5			1993	Alloc-SIR	27,948	887	35	799	(88)	5,989	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATION FROM PREFERRED BOOKKPG			1997	18,448	695	20	922	227	3,513	9
10	ALLOCATION FROM PREFERRED BOOKKPG			1999	146	47	20	7	(40)	11	10
11	ALLOCATION FROM PREFERRED BOOKKPG			2000	925		20	19	19	19	11
12	ALLOCATION FROM SIR PROP-PREFERRED BK			1999	1,872	187	20	94	(93)	140	12
13	ALLOCATION FROM SIR PROP-PREFERRED BK			1998	894	89	20	45	(44)	112	13
14	ALLOCATION FROM SIR PROP-PREFERRED BK			1997	56	6	20	3	(3)	13	14
15	ALLOCATION FROM SIR PROP-PREFERRED BK			1994	141	4	20	7	3	46	15
16	ALLOCATION FROM SIR PROP-PREFERRED BK			1993	240	13	20	12	(1)	90	16
17	ALLOCATION FROM SIR MANAGEMENT			1993	12,004	399	20	606	207	4,731	17
18	ALLOCATION FROM SIR MANAGEMENT			1994	37		20	4	4	24	18
19	ALLOCATION FROM SIR MANAGEMENT			1995	274	16	20	14	(2)	74	19
20	ALLOCATION FROM SIR MANAGEMENT			1999	1,304	86	20	65	(21)	79	20
21	ALLOCATION FROM SIR MANAGEMENT			2000	787	86	20	27	(59)	27	21
22	ALLOCATION SIR PROPRTIES-SIR MGMT			1999	3,541	354	20	177	(177)	266	22
23	ALLOCATION SIR PROPRTIES-SIR MGMT			1998	1,692	169	20	85	(84)	212	23
24	ALLOCATION SIR PROPRTIES-SIR MGMT			1997	105	11	20	5	(6)	24	24
25	ALLOCATION SIR PROPRTIES-SIR MGMT			1994	266	7	20	13	6	86	25
26	ALLOCATION SIR PROPRTIES-SIR MGMT			1993	453	24	20	23	(1)	170	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 85,905	$ 3,549		$ 3,349	$ (200)	$ 18,791	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 447,472	$ 21,524	$ 42,599	$ 21,075		$ 315,081	37
38	Current Year Purchases	74,735	2,050	2,455	405		2,455	38
39	Fully Depreciated Assets	324,328	11,173	1,685	(9,488)		294,328	39
40								40
41	TOTALS	$ 846,535	$ 34,747	$ 46,739	$ 11,992		$ 611,864	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 4,108,524	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 173,628	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 164,877	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (8,751)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,767,413	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

WILSON CARE, INC.
0029975
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
Wilson Care LLC					
Wilson Care, Inc.	386,418	16,906	36,647	19,741	276,585
Preferred Bookkeeping	21,430	1,535	1,989	454	13,144
SIR Properties-Preferred Bookkeeping	14		1	1	10
SIR Management	39,584	3,083	3,959	876	25,322
SIR Properties-SIR Management	26		3	3	20
TOTALS	447,472	21,524	42,599	21,075	315,081

LINE 29: CURRENT YEAR

Wilson Care LLC					
Wilson Care, Inc.	72,869	1,708	2,343	635	2,343
Preferred Bookkeeping	624	125	52	(73)	52
SIR Properties-Preferred Bookkeeping					
SIR Management	1,242	217	60	(157)	60
SIR Properties-SIR Management					
TOTALS	74,735	2,050	2,455	405	2,455

LINE 30: FULLY DEPRECIATED

Wilson Care LLC	30,000				
Wilson Care, Inc.	294,328	11,173	1,685	(9,488)	294,328
Preferred Bookkeeping					
SIR Properties-Preferred Bookkeeping					
SIR Management					
SIR Properties-SIR Management					
TOTALS	324,328	11,173	1,685	(9,488)	294,328

TOTALS (Should Tie to Totals on Page 13)

Wilson Care LLC	30,000				
Wilson Care, Inc.	753,615	29,787	40,675	10,888	573,256
Preferred Bookkeeping	22,054	1,660	2,041	381	13,196
SIR Properties-Preferred Bookkeeping	14		1	1	10
SIR Management	40,826	3,300	4,019	719	25,382
SIR Properties-SIR Management	26		3	3	20
TOTALS	846,535	34,747	46,739	11,992	611,864

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 8,906 Description: SEE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	1999 DODGE	$ 450.00	$ 5,400	17
18	ALLOCATION ECM OWNERS COUNCIL			1,559	18
19	ALLOCATION PREFERRED BOOKKEEPING			2,093	19
20	ALLOCATION SIR MANAGEMENT			6,218	20
21	TOTAL		$ 450.00	$ 15,270	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 295	$	$ 295
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 295	$	$ 295
10	SUM OF line 9, col. 1 and 2 (e)	$ 295			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

STATE OF ILLINOIS

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 57,037	$ 62,900	1
2	Cash-Patient Deposits	14,873	14,873	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	923,588	923,588	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,302	4,302	6
7	Other Prepaid Expenses	1,391	1,391	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	185,890	185,890	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,187,081	$ 1,192,944	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		25,200	13
14	Buildings, at Historical Cost		1,539,800	14
15	Leasehold Improvements, at Historical Cos	1,121,506	1,121,506	15
16	Equipment, at Historical Cost	984,188	1,014,188	16
17	Accumulated Depreciation (book methods)	(1,186,725)	(2,463,957)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	41,887	120,194	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 960,856	$ 1,356,931	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,147,937	$ 2,549,875	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 118,101	$ 118,101	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,907	17,907	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	136,059	136,059	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,923	7,923	31
32	Accrued Real Estate Taxes(Sch.IX-B)	79,500	79,500	32
33	Accrued Interest Payable		28,279	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	23,900	23,900	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	114,075	114,075	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 497,465	$ 525,744	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,578,606	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,578,606	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 497,465	$ 6,104,350	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,650,472	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,147,937	$ #REF!	48

*(See instructions.)

Facility Name & ID Number WILSON CARE, INC. **#** 0029975 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Loan Receivable-Affiliate	185,000	185,000
Interest Receivable	890	890
	185,890	185,890
OTHER NON CURRENT ASSETS:		
Capital Reserve	4,125	4,125
Loan Costs - Net		78,307
R/E Tax Escrow	37,762	37,762
	41,887	120,194

OTHER CURRENT LIABILITIES:	Amount	Amount
Due to Others	1,960	1,960
Due to IDPA-Audit	112,115	112,115
	114,075	114,075
OTHER NON CURRENT LIABILITIES:		
Tenant Escrow-Capital Reserve		

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,847,006	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,847,006	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,567,466	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,764,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (196,534)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,650,472	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	WILSON CARE, INC.	#	0029975	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,847,006
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		1,847,006
Equity(Deficit) from Page 17 Col 1		1,650,472
Related Party		
Equity(Deficit)	-5229856	
Income	24909	
		(5,204,947)
Combined Equity - End of Year		(3,554,475)

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,776,952	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,776,952	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	77,748	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 77,748	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,628	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,628	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,856,328	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,063,256	31
32	Health Care	1,284,071	32
33	General Administration	1,043,158	33
	B. Capital Expense		
34	Ownership	789,675	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	108,702	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,288,862	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,567,466	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,567,466	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **WILSON CARE, INC.** **# 0029975** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	1,200
2	Jury Duty Income (adjusted out on page 5)	52
3	Rent of Space for Pay Phones (adjusted out on page 5)	377
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	1,629

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,881	2,091	$ 59,279	$ 28.35	1
2	Assistant Director of Nursing	1,892	2,117	47,492	22.43	2
3	Registered Nurses	628	628	11,452	18.24	3
4	Licensed Practical Nurses	13,088	13,827	229,697	16.61	4
5	Nurse Aides & Orderlies	65,682	69,364	594,437	8.57	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,594	3,937	56,864	14.44	9
10	Activity Assistants	7,107	7,631	51,844	6.79	10
11	Social Service Workers	8,685	9,112	67,945	7.46	11
12	Dietician					12
13	Food Service Supervisor	1,906	2,291	30,434	13.28	13
14	Head Cook	3,682	3,834	26,902	7.02	14
15	Cook Helpers/Assistants	13,408	14,058	83,138	5.91	15
16	Dishwashers					16
17	Maintenance Workers	3,485	2,841	34,817	12.26	17
18	Housekeepers	15,182	16,010	97,528	6.09	18
19	Laundry					19
20	Administrator	1,833	2,091	87,765	41.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,569	7,092	74,757	10.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,544	5,041	67,032	13.30	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	153,166	161,965	$ 1,621,383 *	$ 10.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	17	$ 728	1-3	35
36	Medical Director	Monthly	3,600	9-3	36
37	Medical Records Consultant	96	4,032	10-3	37
38	Nurse Consultant	SIR MGMT	39,204	10-3	38
39	Pharmacist Consultant	48	1,440	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) SPEC REHAB	SIR MGMT	17,580	10A-3	46
47	DIRECTOR OF FOOD SVC	SIR MGMT	20,196	1-3	47
48	DIETARY CONSULTANT	SIR MGMT	12,000	1-3	48
49	TOTAL (lines 35 - 48)	161	$ 98,780		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	372	$ 9,929	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	372	$ 9,929		53

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CHARLENE HILL-JEON	ADMINISTRATOR	0	$ 87,765
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,765

B. Administrative - Other

Description	Amount
MANAGEMENT FEES-SEE ATTACHED	$ 237,725
MANAGEMENT SERVICE FEES-SEE ATTACHED	69,492
TOTAL (agree to Schedule V, line 17, col. 3)	$ 307,217
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SIR MANAGEMENT	DIR OF REG SERVICES	$ 16,044
PREFERRED BOOKKEEPING	ACCOUNTING FEES	32,500
FROST,RUTTENBERG	ACCOUNTING FEES	11,275
PREFERRED BOOKKEEPING	BOOKKEEPING	59,400
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	788
MID AMERICA PROGRAMMING	COMPUTER	1,320
ICS SOLUTIONS	COMPUTER	975
UNLIMITED TECHNOLOGY	COMPUTER	150
PREFERRED BOOKKEEPING	COMPUTER	4,752
SCHWARTZ & FREEMAN	LEGAL	23,570
STONE, MCGUIRE, BENJAMIN	LEGAL	5,243
SEE ATTACHED SCHEDULE		2,589
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 158,606

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 17,587
Unemployment Compensation Insurance	11,402
FICA Taxes	121,635
Employee Health Insurance	22,091
Employee Meals	17,623
Illinois Municipal Retirement Fund (IMRF)*	
UNION HEALTH AND WELFARE	42,054
EMPLOYEE BENEFITS	11,454
Chicago Head Tax	3,956
TOTAL (agree to Schedule V, line 22, col.8)	$ 247,802

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,710
Health Care Worker Background Check	
(Indicate # of checks performed 8)	93
LICENSE AND FEES	2,100
DUES ANDSUBSCRIPTIONS	6,336
ALLOCATION-PREFERRED	383
ALLOCATION-SIR	1,073
ALLOCATION-ECM OWNER'S COUN	59
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,754

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,637
ALLOCATION PREFERRED	194
ALLOCATION-SIR	581
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,412

**See instructions.

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	06/01/97	$ 14,183	3	$ 2,366	$ 4,727	$ 4,727	$ 2,363	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 14,183		$ 2,366	$ 4,727	$ 4,727	$ 2,363	$	$	$	$	$

Facility Name & ID Number WILSON CARE, INC. # 0029975 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL COUNCIL LTC $6,633**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **108,702**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **17,623** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **Line 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw